

		FOR OHF USE					

LL 1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0046359</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Hillside Health Care</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/15/00</u> to <u>01/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1308 Game Farm Road</u> <u>Yorkville</u> <u>60560</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Kendall</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Robin Underhill</u> (Title) <u>Chief Operating Officer</u>	
Telephone Number: <u>(630) 553-5811</u> Fax # <u>(630)553-2740</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>	
IDPA ID Number: <u>364379329</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>7/15/00</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Maureen Westmiller</u> Telephone Number: <u>(505) 366-5211</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Hillside Health Care# 0046359 Report Period Beginning: 7/15/00 Ending: 01/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>79</u>	Skilled (SNF)	<u>79</u>	<u>15,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>79</u>	TOTALS	<u>79</u>	<u>15,800</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,020</u>	<u>7,295</u>	<u>1,821</u>	<u>13,136</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,020</u>	<u>7,295</u>	<u>1,821</u>	<u>13,136</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 83.14%

D. How many bed-hold days during this year were paid by Public Aid?

3 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONE

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 7/15/00

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 7/15/00 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 16 and days of care provided 2,349Medicare Intermediary Trailblazers

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number

Hillside Health Care

0046359

Report Period Beginning:

7/15/00

Ending:

01/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	61,484	8,940	5,415	75,839		75,839		75,839		1
2	Food Purchase		61,412		61,412		61,412		61,412		2
3	Housekeeping	40,322	3,180		43,502		43,502		43,502		3
4	Laundry	11,890	4,086	9,317	25,293		25,293		25,293		4
5	Heat and Other Utilities			41,651	41,651		41,651		41,651		5
6	Maintenance	11,551	3,084	24,054	38,689		38,689		38,689		6
7	Other (specify):*										7
8	TOTAL General Services	125,247	80,702	80,437	286,386		286,386		286,386		8
	B. Health Care and Programs										
9	Medical Director			5,100	5,100		5,100		5,100		9
10	Nursing and Medical Records	564,566	37,428	2,246	604,240		604,240		604,240		10
10a	Therapy	19,595	323	73,497	93,415		93,415		93,415		10a
11	Activities	16,429	1,318		17,747		17,747		17,747		11
12	Social Services	2,719		194	2,913		2,913		2,913		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*			5,263	5,263		5,263	(5,263)			15
16	TOTAL Health Care and Programs	603,309	39,069	86,300	728,678		728,678	(5,263)	723,415		16
	C. General Administration										
17	Administrative	78,402			78,402	(22,692)	55,710	(17,371)	38,339		17
18	Directors Fees										18
19	Professional Services			16,994	16,994	(197)	16,797	(9,171)	7,626		19
20	Dues, Fees, Subscriptions & Promotions			14,943	14,943		14,943	(4,035)	10,908		20
21	Clerical & General Office Expenses	16,616	7,264	12,138	36,018	22,692	58,710		58,710		21
22	Employee Benefits & Payroll Taxes			164,340	164,340		164,340		164,340		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,497	4,497		4,497	(941)	3,556		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			30,528	30,528		30,528		30,528		26
27	Other (specify):*			127,242	127,242		127,242	(21,139)	106,103		27
28	TOTAL General Administration	95,018	7,264	370,682	472,964	(197)	472,767	(52,657)	420,110		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	823,574	127,035	537,419	1,488,028	(197)	1,487,831	(57,920)	1,429,911		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Hillside Health Care

#0046359

Report Period Beginning:

7/15/00

Ending:

01/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							25,887	25,887			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,615	4,615		4,615		4,615			32
33	Real Estate Taxes			29,795	29,795		29,795	(3,060)	26,735			33
34	Rent-Facility & Grounds			270,990	270,990		270,990		270,990			34
35	Rent-Equipment & Vehicles			16,867	16,867		16,867	(756)	16,111			35
36	Other (specify):*											36
37	TOTAL Ownership			322,267	322,267		322,267	22,071	344,338			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		51,531		51,531		51,531		51,531			39
40	Barber and Beauty Shops			107	107	197	304		304			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			23,858	23,858		23,858	(158)	23,700			42
43	Other (specify):*			7,453	7,453		7,453		7,453			43
44	TOTAL Special Cost Centers		51,531	31,418	82,949	197	83,146	(158)	82,988			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	823,574	178,566	891,104	1,893,244		1,893,244	(36,007)	1,857,237			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Hillside Health Care# 0046359Report Period Beginning: 7/15/00Ending: 01/31/01**VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(15)	27		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,705)	27		24
25	Fund Raising, Advertising and Promotional	(2,489)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(39,685)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (61,894)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule	25,887		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 25,887		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (36,007)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning: 00/03/99
Ending: 7/15/00
01/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
1	Accounting/Audit	\$	19
2	Employee Relations	(1,546)	20
3			3
4	Late Fees	(100)	27
5	Legal Expenses	(6,546)	19
6			6
7	Consulting Rehab-estimated salaries	(5,263)	15
8	Equipment depreciation prior owners (excl van)	25,887	20
9	Meal Income		9
10	Laundry Income		10
11	Vending Income		11
12	Personal Needs Income		12
13	Interest Income		13
14	Other Income		14
15	Equipment Rental Income		15
16	Resident Settlements	(1,211)	27
17	Sales Tax		17
18	Other Insurance-accruals only	(100)	27
19	Minor Equip purch - accruals not reversed	(130)	35
20			20
21	Equipment accruals not reversed	(600)	35
22	Minor Equipment ancillary accrual not reversed	(26)	35
23	Marketing mileage expenses	(941)	24
24	Real Estate Accrual adj	(3,000)	33
25	Provid er tax to agene w/ \$1.50 ppd	(150)	42
26	Marketing Salaries	(17,371)	17
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
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77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(13,798)	90

Summary A

01/31/01

01/31/01

[illegible]

Summary B

Facility Name & ID Number	Hillside Health Care	#	0046359	Report Period Beginning:	7/15/00	Ending:	01/31/01
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Hillside Health Care # 0046359 Report Period Beginning: 7/15/00 Ending: 01/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE NOTE BELOW						NF
		NOTE: We sub-lease from related Party,however, our sub-lessor leases from non-related party.				
		Original owners are not related to Ballantrae or Sub-lessor. Spoke to Randy at State and he said non-related				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V			NOTE: We sub-lease from related Party, however, our sub-lessor and Ballantrae are not related to owner.				16
17	V			See 11.1				17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Hillside Health Care # 0046359 Report Period Beginning: 7/15/00 Ending: 01/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	N/A - no central office costs allocated								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Hillside Health Care# 0046359

Report Period Beginning:

7/15/00Ending: 01/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____)

Fax Number (_____)

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Elite Care Corporation	X		Security Deposit	\$2,189.00	7/15/00	\$ 79,112	\$ 79,112	06/01/05	10.0000	\$ 4,615	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$2,189.00		\$ 79,112	\$ 79,112			\$ 4,615	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 79,112	\$ 79,112			\$ 4,615	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Hillside Health Care**# **0046359** Report Period Beginning: **7/15/00** Ending: **01/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	29,795	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	26,735	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(3,060)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	29,795	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	26,735	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	28,198	8		
	1996	34,728	9		
	1997	66,387	10		
	1998	47,141	11		
	1999	26,735	12		

	FOR OFF USE ONLY			
#2) This is based on when we started leasing the building 7/15/00 -1/31/01 (prorated tax bill accordingly)	13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
#4) This is Tax bill \$49,356 x 6.5 months, which is based on what we pay in escrow to the sub-lessor -See #10.1-10.3	14	PLUS APPEAL COST FROM LINE 5	\$	14
For the purpose of this report, we adjusted the real estate to agree to amount paid of \$26,735	15	LESS REFUND FROM LINE 6	\$	15
(Note: We did not have the prior owners 7/14/00 ending balance)	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

A. Square Feet:

10,565

B. General Construction Type:

Exterior Brick

Frame Masonry

Number of Stories

1

C. Does the Operating Entity?

☐ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 494,040	\$	\$ 25,887	\$ 25,887		\$ 106,536	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40	*only allowed 6 1/2 month of dep							40
41	TOTALS	\$ 494,040	\$	\$ 25,887	\$ 25,887		\$ 106,536	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$			\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$			\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 494,040	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 25,887	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 25,887	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 106,536	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Elite Care Corporation

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>	<u>79</u>	<u>7/15/00</u>	\$ <u>270,990</u>	<u>6</u>	<u>5</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>79</u>		\$ <u>270,990</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 16,111 Description: See 14.1

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ <u> </u>	\$ <u> </u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u> </u>	\$ <u> </u>	21

10. Effective dates of current rental agreement:

Beginning 7/15/00

Ending 1/31/06

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/2001 \$ 479,418

13. 12/2002 \$ 489,006

14. 12/2003 \$ 498,786

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? SEE 15.1 If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input checked="" type="checkbox"/> NO	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
	COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____	
		HOURS PER AIDE _____	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	line 10a col 3	hrs	\$	1,633	\$ 28,676	\$ 271	1,633	\$ 28,947	1
2	Licensed Speech and Language Development Therapist	line 10a col 3	hrs		1,014	15,204		1,014	15,204	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	line 10a col 1	699 hrs	19,595	1,022	29,617	52	1,721	49,264	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	line 39 col 2	# of prescrpts				47,630		47,630	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medical Supplies	line 39 col 2					3,901		3,901	13
14	TOTAL			\$ 19,595	3,669	\$ 73,497	\$ 51,854	4,368	\$ 144,946	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number Hillside Health Care

0046359

Report Period Beginning: 7/15/00

Ending:

01/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/31/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 149,026	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	258,080		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,122		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 410,228	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,934		15
16	Equipment, at Historical Cost	8,051		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SEE 17.3	(149,917)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ (139,932)	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 270,296	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,022	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,998		30
31	Accrued Taxes Payable (excluding real estate taxes)	(4,877)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,550		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	2,733		35
	Other Current Liabilities(specify):			
36	Accrued liabilities -SEE 17.3	6,484		36
37	OTHER-SEE 17.3	50,347		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 97,257	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	128,803		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 128,803	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 226,060	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 44,236	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 270,296	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	77,021	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Intercompany (balance to equity)	196,244	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 273,265	17
	B. Transfers (Itemize):		
18	Intercompany Transfer	(229,029)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (229,029)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 44,236	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Hillside Health Care

0046359

Report Period Beginning: 7/15/00

Ending:

01/31/01

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,917,976	1
2	Discounts and Allowances for all Levels	(5,916)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,912,060	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	137,204	6
7	Oxygen	911	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 138,115	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	62,446	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,102	19
20	Radiology and X-Ray	10,962	20
21	Other Medical Services	59,423	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 140,933	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Revenue - See 19.1	(220,843)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (220,843)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,970,265	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	286,386	31
32	Health Care	728,678	32
33	General Administration	472,964	33
B. Capital Expense			
34	Ownership	322,267	34
C. Ancillary Expense			
35	Special Cost Centers	51,638	35
36	Provider Participation Fee	23,858	36
D. Other Expenses (specify):			
37	lab costs \$1668, Radiology \$5785	7,453	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,893,244	40
41	Income before Income Taxes (line 30 minus line 40)**	77,021	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 77,021	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Hillside Health Care

0046359

Report Period Beginning:

7/15/00

Ending:

01/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,259	1,326	\$ 32,001	\$ 24.13	1
2	Assistant Director of Nursing	838	905	16,998	18.78	2
3	Registered Nurses	4,751	5,050	118,786	23.52	3
4	Licensed Practical Nurses	4,563	4,787	79,686	16.65	4
5	Nurse Aides & Orderlies	26,655	27,978	284,696	10.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	674	699	19,595	28.03	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,383	1,543	16,429	10.65	9
10	Activity Assistants					10
11	Social Service Workers	321	329	2,719	8.26	11
12	Dietician					12
13	Food Service Supervisor	1,133	1,170	14,414	12.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,000	5,224	47,070	9.01	15
16	Dishwashers					16
17	Maintenance Workers	942	1,008	11,551	11.46	17
18	Housekeepers	5,628	5,857	40,322	6.88	18
19	Laundry	1,062	1,102	11,890	10.79	19
20	Administrator	960	1,040	38,339	36.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,030	1,094	16,616	15.19	23
24	Clerical	1,332	1,454	22,692	15.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	764	843	10,238	12.14	31
32	Other Health C; MDS coordinator	1,104	1,126	20,524	18.23	32
33	Other(specify) Marketing & C/S	1,105	1,245	19,008	15.27	33
34	TOTAL (lines 1 - 33)	60,504	63,780	\$ 823,574 *	\$ 12.91	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	155	\$ 5,415	line 1 col 3	35
36	Medical Director	49	5,100	line 9 col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	8	1,700	Line 10 col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	4	194	line 12 col 3	45
46	Other(specify) U/R review	14	546	Line 10 col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	230	\$ 12,955		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **Hillside Health Care**
XIX. SUPPORT SCHEDULES

STATE OF ILLINOIS
 # **0046359**

Page 21
 Report Period Beginning: **7/15/00** Ending: **01/31/01**

A. Administrative Salaries <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 15%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 45%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Nancy Tettermer</td> <td>Administrator</td> <td>none</td> <td>\$ 38,339</td> </tr> <tr> <td>Kimberely Young - reclass</td> <td>Payroll</td> <td>None</td> <td>22,692</td> </tr> <tr> <td>Diane Kay Drake (disallowed)</td> <td>Marketing</td> <td>None</td> <td>17,371</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 78,402</td> </tr> </tbody> </table>	Name	Function	Ownership %	Amount	Nancy Tettermer	Administrator	none	\$ 38,339	Kimberely Young - reclass	Payroll	None	22,692	Diane Kay Drake (disallowed)	Marketing	None	17,371																	TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,402	D. Employee Benefits and Payroll Taxes <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Workers' Compensation Insurance</td> <td>\$ 27,176</td> </tr> <tr> <td>Unemployment Compensation Insurance</td> <td>27,132</td> </tr> <tr> <td>FICA Taxes</td> <td>63,933</td> </tr> <tr> <td>Employee Health Insurance</td> <td>46,099</td> </tr> <tr> <td>Employee Meals</td> <td> </td> </tr> <tr> <td>Illinois Municipal Retirement Fund (IMRF)*</td> <td> </td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 22, col.8)</td> <td>\$ 164,340</td> </tr> </tbody> </table>	Description	Amount	Workers' Compensation Insurance	\$ 27,176	Unemployment Compensation Insurance	27,132	FICA Taxes	63,933	Employee Health Insurance	46,099	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*												TOTAL (agree to Schedule V, line 22, col.8)	\$ 164,340	F. Dues, Fees, Subscriptions and Promotions <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td>IDPH License Fee</td> <td>\$ 363</td> </tr> <tr> <td>Advertising: Employee Recruitment</td> <td>7,800</td> </tr> <tr> <td>Health Care Worker Background Check (Indicate # of checks performed)</td> <td> </td> </tr> <tr> <td>Heaton pub (HC manuals)</td> <td>225</td> </tr> <tr> <td>Illinois HC Assoc.</td> <td>1,924</td> </tr> <tr> <td>Chicago Tribune lounge area</td> <td>203</td> </tr> <tr> <td>Ivans -billing software manual</td> <td>52</td> </tr> <tr> <td>AT & T Cable svcs-for all residents</td> <td>341</td> </tr> <tr> <td>Employee relation & Marketing</td> <td>4,035</td> </tr> <tr> <td>Less: Public Relations Expense</td> <td>(4,035)</td> </tr> <tr> <td>Non-allowable advertising ()</td> <td> </td> </tr> <tr> <td>Yellow page advertising ()</td> <td> </td> </tr> <tr> <td>TOTAL (agree to Sch. V, line 20, col. 8)</td> <td>\$ 10,908</td> </tr> </tbody> </table>	Description	Amount	IDPH License Fee	\$ 363	Advertising: Employee Recruitment	7,800	Health Care Worker Background Check (Indicate # of checks performed)		Heaton pub (HC manuals)	225	Illinois HC Assoc.	1,924	Chicago Tribune lounge area	203	Ivans -billing software manual	52	AT & T Cable svcs-for all residents	341	Employee relation & Marketing	4,035	Less: Public Relations Expense	(4,035)	Non-allowable advertising ()		Yellow page advertising ()		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,908
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* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number **Hillside Health Care**

STATE OF ILLINOIS

0046359

Report Period Beginning:

7/15/00

Ending:

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01/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois HC Assoc. \$1924
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,602 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 23,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: Not performed before filing report The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. not done until September 2001
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.